STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	**234 MANOR CIRCLE ALMA, KS 66401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and Complaint Investigation #KS00075857.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 159	Continued From page 1 The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This Requirement is not met as evidenced by: The facility identified a census of 35 residents and managed 26 residents' personal fund account. Based upon record review and interviews the facility failed to credit quarterly interest earnings to residents' personal funds accounts for 3 (#11,#19, and #29) residents reviewed. Findings included: - Record review on 8/12/14 at 11:24 A.M. revealed resident #11 had a personal funds account that did not received quarterly interest. Interview on 8/12/14 at 11:24 A.M. administrative staff B said the facility should deposit interest into the residents' personal fund accounts monthly for all residents with a personal funds account. He/she said he/she did not credit any resident's personal funds account with monthly interest. Interview on 8/12/14 at 11:30 A.M. administrative staff A said monthly interest, if accrued, was credited to the residents personal funds account. He/she agreed all the residents with personal funds accounts were not getting the interest earned credited into the residents' personal funds	F 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 159	Continued From page 2 accounts. The facility failed to provide a policy on resident personal funds management. The facility failed to credit quarterly interest earnings to the residents' personal funds accounts. - Record review on 8/12/14 at 11:24 A.M. revealed resident #29 had a personal funds account that did not received quarterly interest. Interview on 8/12/14 at 11:24 A.M. administrative staff B said the facility should deposit interest into the residents' personal fund accounts monthly for all residents with a personal funds account. He/she said he/she did not credit any resident's personal funds account with monthly interest. Interview on 8/12/14 at 11:30 A.M. administrative staff A said monthly interest, if accrued, was credited to the residents personal funds account. He/she agreed all the residents with personal funds accounts were not getting the interest earned credited into the residents' personal funds accounts. The facility failed to provide a policy on resident personal funds management. The facility failed to credit quarterly interest earnings to the residents' personal funds accounts. - Record review on 8/12/14 at 11:24 A.M. revealed resident #19 had a personal funds account that did not received quarterly interest. Interview on 8/12/14 at 11:24 A.M. administrative	F 159		

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F 159	Continued From page 3 staff B said the facility should deposit interest into the residents' personal fund accounts monthly for all residents with a personal funds account. He/she said he/she did not credit any resident's personal funds account with monthly interest. Interview on 8/12/14 at 11:30 A.M. administrative staff A said monthly interest, if accrued, was credited to the residents personal funds account. He/she agreed all the residents with personal funds accounts were not getting the interest earned credited into the residents' personal funds accounts. The facility failed to provide a policy on resident personal funds management. The facility failed to credit quarterly interest earnings to the residents' personal funds accounts.	F 159		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 4	F 164		

and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This Requirement is not met as evidenced by:
The facility reported a census of 35 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to provide privacy for 1 (#5) resident who received medications through a percutaneous endoscopic gastrostomy (PEG) tube (a tube passed into the stomach wall for nutritional feeding).

Findings included:

- Observation on 8/5/14 at 3:45 P.M. revealed licensed nursing staff H checked the resident #5's PEG tube for placement, flushed the tube, delivered medications down the tube, attached the PEG to a bag of nutritional fluids. During this time, the staff did not pull the privacy curtain to obscure the resident and did not close the resident's bedroom door. While licensed nursing staff H performed this procedure,a nursing staff looked in when walking by the room.

Interview on 8/5/14 at 3:50 P.M. with licensed nursing staff H stated staff should close the door and pull the privacy curtain for the resident's privacy while staff provided medication and nutrients through the PEG tube.

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	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 164	Continued From page 5 Interview on 8/12/14 at 2:21 P.M. with administrative nursing staff E stated staff should close the door during the medication pass and feeding via the PEG tube. The facility failed to provide a policy and procedure on privacy. The facility failed to provide privacy to this cognitively impaired dependent resident with a PEG tube.	F 164		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This Requirement is not met as evidenced by: The facility identified a census of 35 residents. Based on observation, record review, and interview the facility failed to provide services necessary to maintain a sanitary and comfortable interior of the facility for 2 of 4 days onsite of the survey for 2 of 3 nursing halls. Findings included: - Observations on 8/5/14 at approximately 7:38 A.M. until 5:00 P.M., on 8/6/14 from 7:00 A.M. to 1:00 P.M. and on environmental tour on 8/12/14 at 10:30 A.M. with maintenance staff X revealed the following: Southwest Hallway: Bathrooms had emesis basins on the floor next to the toilets in two residents ' bathrooms, a wall	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 253	Continued From page 6 board had a gouged area near head of the bed, there were scratches inside of a bathroom door, and flies on a resident's face while he/she slept. Southeast Hallway: A resident's bathroom had a urinal on the floor next to the toilet, there were exposed screws in the wall to the left of the sink in a resident's room, a wall in a resident's room had two different colored paints, there were scrapped walls near an air conditioner unit, a scratched bathroom door, a urine odor in a bathroom, one bathroom had feces on the toilet seat, and a live insect in the bathroom. Northeast Hallway: A malodorous (unpleasant smell) was noted in a resident's room. Interview on 8/12/14 at 10:30 A.M. maintenance staff X acknowledged the areas needed repaired and cleaned. The facility failed to provide a policy for general maintenance and cleaning. The facility failed to provide housekeeping and maintenance services in a sanitary orderly and comfortable interior for the residents.	F 253		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's	F 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 273	Continued From page 7	F 273		

physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.)

This Requirement is not met as evidenced by:
The facility identified a census of 35 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to complete an admission Minimum Data Set 3.0 for 1 resident (#43) within 14 days after admission.

Findings included:

- The clinical record indicated the facility admitted resident #43 on 7/15/14.

The clinical record reviewed on 8/11/14 lacked a completed admission Minimum Data Set (MDS) 3.0.

On 8/6/14 at 7:33 A.M. the resident rested in bed.

On 8/11/14 at 12:15 P.M. the resident sat in the main dining room awaiting lunch.

Interview on 8/12/14 at 7:22 A.M. with administrative nursing staff F revealed the facility admitted the resident on 7/15/14 and a comprehensive admission assessment was not completed. He/she had 14 days after they admitted a resident to complete the admission MDS.

Interview on 8/12/14 at 8:20 A.M. with licensed nursing staff J revealed the facility admitted the resident on 7/15/14 and administrative nursing staff F was responsible for completing the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 273	Continued From page 8 assessments. Interview on 8/12/14 at 8:27 A.M. with administrative nursing staff D revealed administrative nursing staff F was responsible for completing the MDS. The admission comprehensive assessment was due 14 day after admission and he/she expected them to be completed within that time frame. The undated MDS (Minimum Data Set) policy provided by the facility revealed it was the policy of the facility to conduct a comprehensive assessment (MDS) according to federal regulations and Medicare guidelines. The facility followed the current RAI (Resident Assessment Instrument) manual for proper procedures on completing the MDS. The facility failed to complete a comprehensive admission MDS within 14 after the facility admitted this resident.	F 273		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 274	Continued From page 9 This Requirement is not met as evidenced by: The facility identified a census of 35 residents. The sample included 18 residents. Based on observation, interview, and record review the facility failed to complete a significant change Minimum Data Set 3.0 for 1 (#24) of 1 residents reviewed for hospice. Findings included: - The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/18/14 for resident #24 revealed the resident was unable to complete to the Brief Interview for Mental Status (BIMS). Staff conducted the assessment for mental status and revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. He/she did not recieve hospice. The quarterly MDS with an ARD of 5/20/14 revealed the resident was unable to complete the BIMS. Staff conducted the assessment for mental status and revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. He/she did not recieve hospice. A telephone order dated 5/14/14 revealed the resident admitted to a local hospice with a terminal diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) with a life expectancy of less than 6 months. The clinical record lacked a significant change MDS indicating the resident was admitted to hospice.	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 274	Continued From page 10 On 8/6/14 at 1:25 P.M. the resident slept in his/her chair in the south living room. On 8/6/14 at 1:45 P.M. 2 staff members transferred the resident to bed using a mechanical lift. Interview on 8/12/14 at 7:24 A.M. with administrative nursing staff F revealed he/she was doing a significant change MDS for resident #24 due to the resident admitted to hospice. The resident admitted to hospice in May 2014 and a significant change MDS was not completed at that time but staff should complete this within 14 days after the change in the resident's condition. Interview on 8/12/14 at 8:20 A.M. with licensed nursing staff J revealed administrative nursing staff F was responsible for completing the MDS assessments. Interview on 8/12/14 at 9:43 A.M. with administrative nursing staff D revealed he/she was not aware when a significant change MDS was required but expected staff to complete them in the required time frame. The undated MDS (Minimum Data Set) policy provided by the facility revealed it was the policy of the facility to conduct a comprehensive assessment (MDS) according to federal regulations and Medicare guidelines. The facility followed the current RAI (Resident Assessment Instrument) manual for proper procedures on completing the MDS. The facility failed to complete significant change MDS within 14 days for this resident who admitted to hospice.	F 274		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

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F 278 SS=D	Continued From page 11 ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This Requirement is not met as evidenced by: The facility identified a census of 35 residents. The sample included 18 residents. Based on observation, interview, and record review, the facility failed to complete an accurate Minimum Data Set 3.0 for 1 of 1 residents (#24) reviewed for pressure ulcers. Findings included:	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 278	Continued From page 12	F 278		

- The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/18/14 for resident #24 revealed the resident did not have pressure ulcers.

The quarterly MDS with an ARD of 5/20/14 revealed the resident did not have pressure ulcers.

A nurses note dated 5/8/14 at 10:30 A.M. revealed the resident had a dime size popped blister of clear fluid to the right heel area and a quarter size blood blister to the left heel area.

On 8/6/14 at 1:25 P.M. the resident slept in his/her chair in the south living room.

On 8/6/14 at 1:45 P.M. 2 staff members transferred the resident to bed using a mechanical lift.

On 8/12/14 at 10:34 A.M. licensed nursing staff J completed a dressing change to the resident's unstagable ulcers on bilateral heels.

Interview on 8/12/14 at 9:00 A.M. with direct care staff R revealed the resident had pressure sores on his/her heels bilaterally.

Interview on 8/12/14 at 10:52 A.M. with administrative nursing staff E revealed he/she was the nurse responsible for staging wounds and fluid filled blisters and blood blisters were unstagable wounds. The 5/20/14 MDS was incorrect.

Interview on 8/12/14 at 1:10 P.M. with administrative nursing staff F revealed on an MDS, blisters were coded as unstagable wounds.

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F 278	Continued From page 13 Interview on 8/12/14 at 12:57 P.M. with administrative nursing staff D revealed he/she was unsure what blisters were coded on the MDS but expected staff to complete the MDS accurately. The undated MDS (Minimum Data Set) policy provided by the facility revealed it was the policy of the facility to conduct a comprehensive assessment (MDS) according to federal regulations and Medicare guidelines. The facility followed the current RAI (Resident Assessment Instrument) manual for proper procedures on completing the MDS. The facility failed to accurately complete the MDS for this resident with unstagable wounds.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 14 under §483.10(b)(4). This Requirement is not met as evidenced by: The facility identified a census of 35 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to develop a comprehensive care plan for 2 of 3 residents reviewed for accident hazards (#37, #36) and 1 of 3 residents reviewed for activities of daily living (ADL) cares (#28) and 1 of 1 reviewed for hospice services (#24). Findings included: - Resident #37's August 2014 electronic record noted the resident had a diagnosis of bilateral below the knee amputation (calf and foot surgically removed below the knee on both legs). The 3/5/14 admission Minimum Data Set (MDS) 3.0 assessment recorded the resident's Brief interview for Mental Status score of 14 indicating the resident's cognition was intact. The resident required extensive assistance of 1 to 2 staff with bed mobility, transfers, dressing, toilet use and personal hygiene, had occasional bladder incontinence and received diuretic medication (a medication to remove excess fluid from the body). The ADL and Fall Care Area Assessment (CAA) dated 3/5/14 recorded the resident used a wheel chair for mobility and a seat belt due to his/her history of falls and a fear of falling. The CAA lacked documentation of other assistive devices, such as a bed cane for positioning and mobility.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 15 Review of the 8/6/14 side rail assessment recorded: "Analysis should include a statement that side rails were not being used as a restraint and discuss what will be used such a a bed cane, quarter side rails etcetera." The resident's care plan dated 8/6/14 lacked documentation of the residents use of a bed cane for positioning and/or bed mobility. On 8/5/14 at 2:51 P.M. the resident sat upright in his/her wheelchair. The resident had a hoop type bed cane on both sides his/her bed. On 8/11/14 at 1:15 P.M. administrative staff members D and F acknowledged the resident's care plan should include the bed cane positioning devices. The undated Comprehensive care plan policy recorded: Each residents care plan was individualized and reflected the physical and psychosocial issues/concerns and interventions for the resident. The facility failed to develop an individualized comprehensive care plan that included the use of bed cane positioning devices for this dependent resident. - Resident #36's August 2014 electronic record noted the resident had a diagnosis of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought). The 3/11/14 quarterly Minimum Data Set (MDS) 3.0 assessment recorded the resident with a Brief	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 16	F 279		

interview for Mental Status score of 15 indicating the resident's cognition was intact. The resident required minimal assistance of one staff with most ADL's toileted his/herself, had a history of falls and received diuretic medications.

The ADL and Fall Care Area Assessment (CAA) dated 6/6/14 lacked documentation of assistive devices, such as a bed cane for positioning and mobility.

Review of the 8/6/14 side rail assessment recorded: "Analysis should included a statement that side rails are not being used as a restraint and discuss what will be used such a a bed cane, quarter side rails etcetera."
The resident's care plan dated 8/6/14 lacked documentation of the residents use of a bed cane for positioning and/or bed mobility.

Observation on 8/11/14 at 8:30 A.M. revealed the resident laid in his/her bed sleeping with his/her right hand grasping a hoop type bed cane attached to the beds right side.

Interview on 8/11/14 at 1:15 P.M. administrative staff members D and F acknowledged the resident'scare plan should included the bed cane positioning devices.

The undated comprehensive care plan policy recorded: Each residents care plan will be individualized and reflected the physical and psychosocial issues/concerns and interventions for the resident.

The facility failed to develop an individualized comprehensive care plan that included the use of bed cane postponing devices for this independently mobile resident with a hisory fo

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 17 falls. - Electronic Health Record (EHR) reviewed on 8/6/14 at 3:32 P.M. revealed resident #28 had a diagnosis of schizoaffective disorder (SAD) (a mental disorder characterized by abnormal thought processes and deregulated emotions). The annual Minimum Data Set (MDS) 3.0 dated 6/3/14 revealed a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact).The resident was independent with bed mobility, transfers, walking in her/his room/corridor, locomotion on/off the unit, and dressing. The resident required supervision of one person for dressing and personal hygiene, supervision with set up for eating, independent with setup for toilet use, and supervision of one person with bathing. The resident did not have functional limitation in range of motion to her/his upper/lower extremities and did not use a mobility device. The Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 6/11/14 revealed the resident performed all her/his ADL's independently with set up assistance of one for toileting, hygiene/bath and eating. She/he received a regular diet and obtained fluids independently. The resident was diagnosed with Schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought) with anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) and a history of agitation and could become very aggressive. She/he preferred showers in the afternoon on	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 18	F 279		

Wednesday and Saturdays,required encouragement/reminders and some set up assistance to take her/his showers, change clothes, and for hygiene. She/he would choose not to bath, change clothes and then could begin to look unclean/unkept with body odor. Would require continued observations, set up, and verbal reminders/encouragement assistance from one staff.

The revised care plan dated 3/6/14 for the resident's appearance was never a high priority and still not a priority revealed nursing staff would encourage the resident to trim her/his nail on bath days and as needed (PRN). She/he may refused but nursing staff offered. Nursing staff would assist the resident in arranging her/his bath and preferred to take showers in the afternoon on Wednesday and Saturday. The resident was unable to wash her/his back and hair and required staff assistance. She/he was not concerned how her/his hair looked and often she/he did not comb it. The resident preferred to get up at 6:00 A.M. to (-) 7:00 A.M. and go to bed at 8:00 P.M. The resident walked around the facility without an assistive device and if staff noticed the resident getting weak or unsteady they would let the nurse know. If the resident showed signs of weakness and not able to perform tasks as usual, the nurse was notified immediately.

The care plan dated 3/6/14 lacked documentation the resident required encouragement to change soiled/stained clothing.

Observation on 8/6/14 at 10:45 A.M. revealed the resident's clothes were dirty with food stains and her/his hair was uncombed. At 5:00 P.M. observation revealed the resident wore the same

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 19 stained clothes to evening meal. Observation on 8/12/14 at 6:30 A.M. revealed the resident wore a dirty shirt. Interview on 8/11/14 at 3:05 P.M. with direct care staff R stated the resident was independent with personal hygiene and dressing and became agitated with staff when encouraged to comb hair and to wear clean clothes. Interview on 8/11/4 at 3:15 P.M. with licensed nursing staff H stated the resident became very agitated and growled at nursing staff if they attempted to encourage/assist the resident with grooming and/or clothing. It depended on the resident's mood if she/he allowed nursing staff help with personal grooming. Interview on 8/12/14 at 11:43 A.M. with administrative nursing staff D stated the resident liked to have her/his clothes changed on shower days and nursing staff tried other approaches to encourage the resident to brush her/his hair and to wear clean clothes. The care plan should reflect and individualize nursing staff approaches. The undated policy and procedure titled Comprehensive Care Plans revealed it was the facility's policy to develop a comprehensive care plan for each resident that included measurable objectives to meet a resident's medical, nursing, mental, and psychosocial needs and were consistent with the resident's desires and preferences. Each resident's care plan was individualized and reflected the physical and psychosocial issues/concerns and interventions for the resident. The preference and goals of the resident was given the highest priority in care plan development.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 20 The facility failed to provide a comprehensive ADL care plan for this independent resident who required supervision and had a diagnosis of schizoaffective disorder. - The electronic health record for resident #24 revealed a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion). The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/18/14 revealed the resident was unable to complete to the Brief Interview for Mental Status (BIMS). Staff conducted the assessment for mental status and revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. The resident was at risk for developing pressure ulcers, did not have pressure ulcers, had a pressure reducing device for the chair and bed, and was on a turning and repositioning program. The Care Area Assessment (CAA) for Activities of Daily Living (ADL) functional/rehabilitation potential dated 2/20/14 revealed due to osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), dementia, and loss of functional range of motion in the upper body the resident was functioning at his/her best ability. He/she needed extensive assistance to total assistance for all ADL's, had therapy in the past but with depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and back pain never made much progress, and wore a palm gripper in the left hand to prevent soreness from squeezing the hand	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 21	F 279		

closed. Staff needed to encourage and allow him/her to continue to use his/her hands to wash the face and feed him/herself finger foods.

The CAA for pressure ulcers dated 2/21/14 revealed the resident had no pressure ulcers and no history, had a braden score of 15 so was at high risk for pressure ulcers, used a pressure relieving mattress on his/her bed and a cushion in the wheelchair and recliner. His/her weight was stable, the resident was fed by staff and ate well. The resident was repositioned every 2 hours and had skin protectant applied after all incontinent episodes and with peri care.

The quarterly MDS with an ARD of 5/20/14 revealed the resident was unable to complete the BIMS. Staff conducted the assessment for mental status and revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. He/she was at risk of developing pressure ulcers, did not have a pressure ulcer, had pressure reducing devices for the chair and bed, was on a turning and repositioning program, and received hospice care.

The hospice care plan dated 7/8/14 revealed the resident utilized hospice and comfort measures to ensure maximum quality of life. A hospice volunteer was available to the resident or family if needed but did not visit on a regular schedule. Staff coordinated the resident's care with hospice to assure all needs were met. In addition to medications, hospice provided incontinent briefs, gloves, wipes, skin barrier cream, toothettes, and lotion. In addition to the cares the facility provided, the hospice aide visited 1 to 2 times a week and offered a bath or shower 1 time a week, shampooed the resident's hair, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 22	F 279		

trimmed and filed his/her nails. Staff provided the resident with medications and other measures to maintain comfort per the care plan. Medications provided by hospice were indicated on the Physician's Order Sheet. The hospice chaplain visited 1 to 2 times a month and additionally if needed to provide spiritual support to the resident and family. The hospice nurse visited 1 to 2 times a week to assess the resident's status and evaluate the need for changes in the plan of care. The hospice social worker visited 1 to 2 times a month.

The hospice care plan lacked information regarding wound assessment and care for this resident.

A nurses's note dated 5/8/14 at 10:30 A.M. revealed a dime size popped blister of clear fluid to the right heel area and a quarter size blood blister to the left heel area.

Telephone orders dated 5/23/14, 6/6/14, 7/11/14, 7/16/14, 7/30/14, and 8/6/14 revealed treatment orders from hospice for the wounds to the resident's heels.

The clinical record lacked measurements for the resident's heel wounds from 5/8/14 until 8/7/14.

A wound and skin progress note completed by the facility's wound nurse dated 8/7/14 revealed a right heel wound 3.5 centimeters (cm) in length by 3.0 cm in width. The area was described as hard dried skin.

A wound and skin progress note completed by the facility's wound nurse dated 8/7/14 revealed a left heel wound 3.0 cm in length by 4.0 cm in width that started as a fluid filled blister, became

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 23 hard and was now peeling off. Review of the hospice record for resident #24 revealed measurements and assessments of the bilateral heel wounds on 5/23/14, 5/30/14, 6/11/14, 6/18/14, 6/25/14, 7/11/14, 7/16/14, and 7/30/14. On 8/6/14 at 1:25 P.M. the resident slept in his/her chair in the south living room and wore bilateral cushioned heel protectors. On 8/6/14 at 1:45 P.M. two staff members transferred the resident to his/her bed using a mechanical lift. His/her heel protectors were on and the heels floated off the bed. On 8/12/14 at 8:02 A.M. direct care staff R revealed he/she looked on a resident's care plan to know what care they needed. On 8/12/14 at 9:00 A.M. direct care staff R revealed hospice came to the facility on Tuesday and Thursday, gave the resident baths and provided briefs and wipes. Interview on 8/12/14 at 9:09 A.M. with licensed nursing staff J revealed hospice did skin assessments, bathed the resident, did dressing changes, provided supplies and medications, monitored the treatment for heel wounds was appropriate, and obtained any needed orders from the physician. Interview on 8/12/14 at 10:52 A.M. with administrative nursing staff E revealed the wound nurse was responsible for measuring and staging wounds. The floor nurses did the wound treatments and hospice obtained the treatment orders.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 24 The undated comprehensive care plan policy provided by the facility revealed it was the facility's policy to develop a comprehensive care plan for each resident that included measurable objectives to meet a resident's medical, nursing, and mental and psychosocial needs and are consistent with the resident's desires and preferences. The facility failed to develop a comprehensive individualized care plan for this resident with pressure ulcers who recieved hospice care.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility identified a census of 35 residents.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 25	F 280		

The sample included 18 residents. Based on observation, interview, and record review, the facility failed to update the care plans for 1 resident (#24) for treatment and medication orders.

Findings included:

- The electronic record for resident #24 revealed a diagnosis of contractures (abnormal permanent fixation of a joint) of the hand and upper arm.

The annual Minimum Data Set (MDS) 3.0 with an Assessment Reference Date (ARD) of 2/18/14 revealed the resident was unable to complete to the Brief Interview for Mental Status (BIMS). Staff conducted the assessment for mental status and revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. The resident required extensive assistance of 2 or more people for bed mobility, transfers, walking in the room, dressing, and toilet use, and extensive assistance of 1 for locomotion, eating and personal hygiene, was totally dependent on 1 for bathing, had range of motion impairment on both sides of upper extremities, used a wheelchair, and had no range of motion or splint time.

The Care Area Assessment (CAA) for Activity of Daily Living (ADL) functional/rehabilitation potential dated 2/20/14 revealed due to osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), dementia (progressive mental disorder characterized by failing memory, confusion), and loss of functional range of motion in the upper body the resident was functioning at his/her best ability. He/she needed extensive assistance to total assistance for all ADL's, had therapy in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 26	F 280		

past but with depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and back pain never made much progress, and wore a palm gripper in the left hand to prevent soreness from squeezing the hand closed. Staff needed to encourage and allow the resident to continue to use his/her hands to wash his/her face and eat finger foods.
The quarterly MDS with an ARD of 5/20/14 revealed the resident was unable to complete to the BIMS. Staff assessment for mental status was conducted and revealed the resident had short and long term memory problems and moderately impaired cognitive skills for daily decision making. He/she was totally dependent and required assistance of 2 or more people for transfers and dressing, was totally dependant and required assistance of 1 for locomotion, required extensive assistance of 2 or more for bed mobility and toilet use, extensive assistance of 1 for eating and personal hygiene, did not walk, was totally dependant and required assistance of 2 or more for bathing, had impairment in range of motion in the bilateral upper extremities, received passive range of motion 3 of the prior 7 days for at least 15 minutes, active range of motion 3 of the prior 7 days for at least 15 minutes and had splint assistance 7 of the prior 7 days.

The skin care plan last reviewed 5/27/14 revealed the resident had a left elbow splint on between meals,off at meal time and at night.

The restorative care plan last reviewed 5/27/14 revealed the resident had a diagnosis of a contracture of the tendon of the left arm. He/she could not move the hand or elbow without help, needed exercises to keep up strength and ability to move, wore a brace on the left elbow during

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 27 the day and off at night, and continued passive range of motion. A telephone order dated 6/4/14 revealed the arm brace was discontinued per family request. A restorative note dated 6/30/14 at 4:22 P.M. revealed the resident was on hospice and no longer wore his/her braces, per family requests as they were uncomfortable for him/her. On 8/6/14 at 1:25 P.M. the resident slept in his/her chair in the south living room, palm protectors were in both hands, and he/she did not wear an arm brace. On 8/11/14 at 9:30 A.M. the resident slept in bed, palm protectors were in both hands, and the resident did not wear an arm brace. Interview on 8/12/14 at 9:00 A.M. with direct care staff R revealed the resident did not wear an arm brace at this time. Hospice discontinued the brace because it caused the resident discomfort. Interview on 8/12/14 at 10:20 A.M. with direct care staff Q revealed the resident had an arm brace in the past but hospice discontinued it because it was causing him/her pain and he/she did not wear it anymore. Interview on 8/12/14 at 9:09 A.M. with licensed nursing staff J revealed the resident wore palm protectors but no brace. Interview on 8/6/14 at 3:38 P.M. with administrative nursing staff E revealed the care plans on the computer were working care plans and the nurses were to put interventions in history if they no longer applied.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMA MANOR	234 MANOR CIRCLE ALMA, KS 66401

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F 280	Continued From page 28 Interview on 8/12/14 at 7:40 A.M. with administrative nursing staff F revealed he/she updated the care plan with the MDS process and the nurses made some changes to the care plans but the facility preferred the nurses did not make a lot of changes. He/she reviewed all of the changes to care plans. Interview on 8/12/14 at 9:45 A.M. with administrative nursing staff D revealed the resident did have an upper arm splint that was discontinued per family request as they believed it was causing the resident pain. Administrative nursing staff F was responsible for updating care plans, he/she reviewed daily orders and made changes to the care plans as needed, and the nurses working the floor also updated the care plan as needed. The undated comprehensive care plan policy provided by the facility revealed the interdisciplinary team met weekly and revised the care plan as needed. The facility failed to update the care plan for this resident who no longer used an arm splint.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 323	Continued From page 29	F 323		

The facility identified a census of 35 residents. The sample included 18 residents. Based on observation, record review, and interview, the facility failed to ensure the resident environment remained free of accident hazards related to the use of bed cane positioning devices for 2 of 3 residents reviewed for accident hazards (#37, #36).

Findings included:

- Resident #37's August 2014 electronic record noted the resident had a diagnosis of bilateral below the knee amputation (calf and foot surgically removed below the knee on both legs).

The 3/5/14 admission Minimum Data Set (MDS) 3.0 assessment recorded the resident with a Brief interview for Mental Status score of 14 indicating the resident's cognition was intact. The resident required extensive assistance of 1 to 2 staff with bed mobility, transfers, dressing, toilet use and personal hygiene, and had occasional bladder incontinence and received diuretic medication (a medication to remove excess fluid from the body).

The activities of daily living (ADL) and Fall Care Area Assessment (CAA) dated 3/5/14 recorded the resident used a wheelchair for mobility and a seat belt due to his/her history of falls and a fear of falling more. The CAA lacked documentation of other assistive devices, such as a bed cane for positioning and mobility.

Review of the 8/6/14 side rail assessment recorded: "Analysis should included a statement that side rails are not being used as a restraint and discuss what will be used such a a bed cane, quarter side rails etcetera."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 323	Continued From page 30 The residents care plan dated 8/6/14 lacked documentation of the residents use of a bed cane for positioning and/or bed mobility. Observation on 8/5/14 at 2:51 P.M. revealed the resident sat upright in his/her wheelchair. The resident had a hoop type bed cane on both sides his/her bed. This oblong shaped bed cane measured 11 inches wide (horizontal opening) and 6 and 1/4 inches tall (vertical opening) and created a potential entrapment hazard for a resident's head and/or extremities. The Food and Drug Administrations (FDA) Potential Zones of Entrapment guidance revealed: Zone 1 (within the rail) was a potential zone of entrapment, and recommended an opening for the head and neck of no greater than 4 and 3/4 inches and 2 and 3/8 inches respectively. Interview on 8/11/14 at 1:15 P.M. administrative staff members D and F said they were unaware the resident's bed cane positioning devices were potential hazards. The undated side rail utilization policy recorded the use of a bed cane, transfer pole, trapeze, or other adaptive equipment was utilized to aid the resident in repositioning however lacked documentation of specific measurements. The facility failed to provide a safe and secure environment free of potential accident hazards for this dependent resident.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 31	F 323		

- Resident #36's August 2014 electronic record noted the resident had a diagnosis of schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbances of language and communication and fragmentation of thought).

The 3/11/14 quarterly Minimum Data Set (MDS) 3.0 assessment recorded the resident with a Brief interview for Mental Status score of 15 indicating the resident's cognition was intact. The resident required minimal assistance of one staff with most ADL's toileted his/herself, had a history of falls and received diuretic medications.

The activities of daily living (ADL and Fall Care Area Assessment (CAA) dated 6/6/14 lacked documentation of assistive devices, such as a bed cane for positioning and mobility.

Review of the 8/6/14 side rail assessment recorded: "Analysis should included a statement that side rails are not being used as a restraint and discuss what will be used such a a bed cane, quarter side rails etcetera."

The residents care plan dated 8/6/14 lacked documentation of the residents use of a bed cane for positioning and/or bed mobility.

Observation on 8/11/14 at 8:30 A.M. revealed the resident laid in his/her bed sleeping with his/her right hand grasping a hoop type bed cane attached to right side of the bed. This oblong shaped bed cane had a 11 inch wide (horizontal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 323	Continued From page 32 opening) and 6 and 1/4 inches tall (vertical opening) and created a potential entrapment hazard for a residents head and/or extremities. The Food and Drug Administrations (FDA) Potential Zones of Entrapement guidance revealed: Zone 1 (within the rail) was a potential zone of entrapment and recommended an opening for the head and neck of no greater than 4 and 3/4 inches and 2 and 3/8 inches respectively. Interview on 8/11/14 at 1:15 P.M. administrative staff members D and F stated they were unaware the resident's bed cane positioning devices were potential hazards. The undated side rail utilization policy recorded the use of a bed cane, transfer pole, trapeze, or other adaptive equipment is to be utilized to aid the resident in repositioning however lacked documentation of specific measurements. The facility failed to provide a safe and secure environment free of potential accident hazards for this independently mobile resident.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 33	F 325		

This Requirement is not met as evidenced by:
The facility reported a census of 35 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to monitor the percentage of intake for 1 (#10) of 3 residents sampled for nutrition.

Findings included:

- The quarterly Minimum Data Set (MDS) 3.0 dated 7/1/14 for resident #10 revealed the resident's short/long term memory was intact, she/he was able to recall the location of her/his room, new staff's names and faces, that she/he was in a nursing home, and was moderately impaired for cognitive skills for daily decision making. The resident had daily occurrence of rejection of care, required supervision with set up assistance with bed mobility, was independent with set up assistance with transfers and eating, was independent with walking in room/corridor,required supervision of one person with locomotion on the unit, required limited supervision of one person for locomotion off the unit, dressing, toilet use, and personal hygiene, and required extensive assistance of one person for bathing. The resident did not have functional limitations in range of motion (ROM) in her/his upper/lower extremities and did not use a mobility device. The resident did not have any swallowing difficulties, weighed 148 pounds (#) for a height of 62 inches, had a weight loss of 5 percent (%) or more in the last month or loss of 10% in more in last 6 months and not on a physician weight loss diet. The resident received a therapeutic diet and did not have any oral/dental concerns.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 34 The admission MDS 3.0 dated 4/15/14 revealed a BIMS score of 13 (cognitively intact). No behaviors were demonstrated. The resident was independent with set up with bed mobility, dressing, eating, toilet use, and personal hygiene, was independent with transfers, walking in her/his room/corridor, locomotion on/off the unit, and was required supervision with set up with bathing. The resident did not have any functional limitation in ROM to her upper/lower extremities and did not use a mobility device. The resident did not have swallowing disorders, weighed 167# for a height of 62 inches, had no weight loss/gain, and no oral/dental concerns. The Nutritional Care Area Assessment dated 4/18/14 indicated staff should review the Nutritional Registered Dietitian's assessment of 4/15/14. The revised nutritional care plan dated 7/16/14 for not eating and lost weight because of her/his mental status revealed the resident received super pudding with meals, nursing staff assisted the resident with maintaining her/his weight, and if she/he ate all her/his meal the resident may not want her/his super pudding. The resident had problems wanting to eat and required assistance from staff by providing finger foods and snacks. The resident received health shakes three times a day between meals and at night (HS). The liked to eat in her/his room but that made it difficult for staff to monitor the resident's intake of food. The required the certified nursing aide (CNA) to monitor the amount of food the resident ate by obtaining the dishes from the prior meal when the current meal was left, and nursing staff weighed the resident weekly.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 35 The Monthly weights reported on the electronic health record (EHR) on 8/11/14 at 3:33 P.M. listed the following: 4/8/14 167# 5/6/14 159# 6/3/14 156# 7/9/14 144# 8/6/14 140# A 27# weight loss. The % of Meal Intake form for 8/1/14 to (-) 8/11/14 lacked documentation for the % of meal intake for all three meals on 8/6/14, 8/9/14 - 8/11/14 and for the evening meal documentation on 8/3/14, 8/5/14, and 8/8/14. The facility was unable to provide documentation for % of meal intakes for the past 3 months (May 2014, June 2014, and July 2014). On 8/11/14 at 7:43 A.M. the resident ambulated through the dining room and then went back to bed and at 9:39 A.M. a plastic covered plate of egg sandwich and pudding cup sat at the bedside untouched while the resident slept. On 8/11/14 at 10:22 A.M. the resident slept and did not wake when nursing staff knocked loudly and loudly asked the resident if she/he would like her/his shake. Nursing staff left the shake at the bedside while the resident slept. On 8/11/14 at 12:34 P.M. the resident ate 75% of her/his lunch and staff offered the resident a variety of foods. Nursing staff provided 3 servings of corn, ate 100% chocolate ice cream and 50% of the supper pudding. On 8/12/14 at 10:30 A.M. direct care staff R stated the medication nurse documented the % of	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 325	Continued From page 36 meal intake and only for those residents identified as having a weight loss. On 8/12/14 at 10:34 A.M. with licensed nursing staff H stated the nursing staff who passed medications documented the % of meal intake for those residents with weight loss and the nurse was responsible to ensure the form was completed. On 8/12/14 at1:33 P.M. licensed nursing staff I stated the medication nurse documented on the % of meal intake form. The % of meal intake form was initiated if there was a 3 pound gain/loss. On 8/12/14 at 11:34 A.M. nursing staff stated the medication nurse documented the % of meal intake for those resident identified as having weight loss and nursing staff reviewed the forms at the Resident at Risk meetings. On 8/12/14 at 1:39 P.M. with administrative nursing staff E stated the % of meal intake were utilized for residents identified as having a 3# weight gain/loss in one week. She/he searched for the resident's past 3 months of % of meal intake and was unable to find them. A staff member was responsible for collecting the monthly forms and handing them in quarterly and that staff member was not with the facility. The facility failed to provide a policy and procedure for the % of meal intake monitoring. The facility failed to monitor the % of meal intake for this resident with moderately impaired cognitive skills for daily decision making and with weight loss.	F 325		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 37 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility identified a census of 35 residents. The sample included 18 residents. Based on observation, record review, and interview the facility failed to monitor medications for 1 of 5 residents reviewed for unnecessary medications (#35). Findings included:	F 329		

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F 329	Continued From page 38 - The quarterly Minimum Data Set (MDS) 3.0 dated 7/27/14 revealed resident #35 had a Brief Interview for Mental Status (BIMS) score of 13 (cognitively intact). The resident received an antidepressant medication. The Psychotropic Drug Use Care Area Assessment (CAA) dated 5/2/14 revealed the resident had a diagnosis of insomnia (inability to sleep) and received Trazadone (an antidepressant). The care plan dated 5/2/14 for black bock warning medications revealed the resident received Trazadone and nursing staff would monitor the resident for side effects. Review of the electronic health records on 8/11/14 at 9:13 A.M. revealed a physician's order on 7/17/14 for Trazadone 100 milligrams (mg) by mouth (PO) daily at night (HS) for insomnia. The Sleep Assessment dated 7/17/14 revealed the resident did not have any sleep issues nor received any medications to aide in falling asleep. Observation on 8/11/14 at 8:29 A.M. revealed the resident sat in a wheelchair in the dining room. Interview on 8/12/14 at 10:12 A.M. with administrative nursing staff D stated the sleep assessment should reflect the resident received Trazadone for sleep and the sleep assessment was incorrect. The undated policy and procedure titled Sleep Assessment revealed during the time a resident continued to receive a medication to aide in sleep, the Sleep Assessment was completed upon readmission, quarterly, and with any significant change in condition.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175346	A. BUILDING _____ B. WING _____	08/14/2014

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F 329	Continued From page 39 The facility failed to accurately assess/complete an sleep assessment for this resident who received Trazadone for insomnia.	F 329		
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This Requirement is not met as evidenced by: The facility reported a census of 35 residents. Based on observation, interview, and record review the facility failed to maintain working call light system on 3 of 3 halls. Findings included: - Call light checks on 8/6/14 from 10:00 A.M. to 10:45 A.M. revealed the following: A room call light on the north east hall did not illuminate outside the room or remain illuminated at the panel at the nurse's desk. A room call light on the south east hall did not illuminate at the panel at the nurse's desk and the bathroom light did not illuminate outside the door. A bathroom call light on the south east hall did not illuminate outside the door or at the panel at the nurses desk. A room and bathroom call light on the south west hall did not illuminate outside the door. The log of the call light checks provided by the facility revealed call light checks due 5/31/14	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 463	Continued From page 40	F 463		

were completed on 5/30/14. Call light checks due 6/30/14 were completed on 7/8/14 and call light checks due 7/31/14 were completed on 7/14/14.

Interview on 8/6/14 at 10:32 A.M. with direct care staff P revealed if a call light did not work he/she told the maintenance supervisor verbally.

Interview on 8/6/14 at 10:33 A.M. with licensed nursing staff J revealed he/she contacted the maintenance supervisor if a call light did not work and moved the resident to a different room so the resident had a way to call for help until it was fixed.

Interview on 8/6/14 at 10:35 A.M. with licensed nursing staff H revealed he/she filled out a work order if a call light did not work or called maintenance.

Interview on 8/6/14 at 10:55 A.M. with maintenance staff X revealed he/she checked every call light monthly.

Interview on 8/12/14 at 8:27 A.M. with administrative nursing staff D revealed maintenance staff X completed call light checks and he/she expected them to always work for all residents.

The facility failed to provide a policy pertaining to the functioning of the call light system.

The facility failed to have working call lights for all residents of the facility.